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BOARD MEETING

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE

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Gotham Building
42-09 28th Street
Long Island City, New York

Tuesday, March 13, 2018
10:01 a.m.

APPEARANCES:

MARY T. BASSETT, MD, MPH
Chair

SIXTO R. CARO, MD
Board Member

JOEL A. FORMAN, MD
Board Member

DEEPTHIMAN K. GOWDA, MD, MPH
Board Member

LYNNE D. RICHARDSON, MD, FACEP
Board Member

GAIL B. NAYOWITH, MSW
Board Member

SUSAN KLITZMAN, DrPH, MPH, CPH
Board Member

KAREN B. REDLENER, MS
Board Member

RAMANATHAN RAJU, MD
Board Member

THOMAS MERRILL, ESQ.
General Counsel

ROSLYN WINDHOLZ, ESQ.
Deputy General Counsel

DR. BASSETT: Good morning, everyone. I'm going to call the meeting to order. This is the Board of Health meeting. Our first item of business this morning is to approve the minutes from our last meeting, which was held six months ago on September 12, 2017.

The minutes include the stenographer's minutes, which are incomplete because the stenographer was delayed in arrival, and some additional minutes that were provided by our Department.

I'd like to ask the Board to approve these minutes in their entirety, both the minutes that we supplied and those supplied by the secretary. But first, can I hear any questions about the minutes?

DR. FORMAN: (Indicating.)

DR. BASSETT: Dr. Forman, welcome back. We've missed you.

DR. FORMAN: Thank you, Dr. Bassett. Yes, I was sorry to miss that meeting. I enjoyed reading the minutes that we

did have, and maybe I'll just hand it in -- I counted up to six -- what I'm pretty sure are content errors that I had said, reading out to you all, I could just type up and give to the stenographer. They are by page and line, and they are just content issues that I think are pretty obvious.

DR. BASSETT: Okay. Thank you, as ever, for your careful reading.

Are there any other comments?

MS. REDLENER: Just a small thing, I think there's some inconsistency with titles of people who are speaking. Sometimes doctors are referred to as "Ms.", sometimes as "Dr." Miss, M-I-S-S was part of the minutes. It should be "Ms." I would just ask for a little consistency and accuracy about that.

DR. BASSETT: Were those among your corrections?

DR. FORMAN: No.

DR. BASSETT: Going forward, will you supply those corrections?

MS. REDLENER: I will supply those

corrections.

DR. BASSETT: We will happily provide them to be included in the corrections to the minutes. Are there any further comments from the Board? If not, may I have a motion to adopt the minutes?

MS. NAYOWITH: (Indicating.)

DR. FORMAN: Second.

DR. BASSETT: We have a second. All in favor, please say yes.

ALL: Yes.

DR. BASSETT: So I take that as unanimous. The minutes are approved.

This morning we have two items for the Board's consideration that were previously approved for publication and three items that are brought to you for consideration for approval for publication.

We are going to begin with a notice of adoption to amend Article 11 and Article 13 of the New York City Health Code. Do we have a presentation?

DR. DASKALAKIS: (Indicating.)

DR. BASSETT: Dr. Daskalakis, can you state your name for the record and take us through the presentation?

DR. DASKALAKIS: Thank you. I'm Demetre Daskalakis, Deputy Commissioner for Disease Control, New York City Department of Health. Good morning.

Thank you for your attention. Today we will walk through proposals to amend Health Code Articles 11 and 13 for disease surveillance. So there are two areas that we are looking to amend.

The first is Article 11 to require the reporting of carbapenem-resistant Enterobacteriaceae infections. We will call those CRE the rest of the time, just so I don't trip over Enterobacteriaceae. We will also present amending Article 13 to require laboratories to report all hepatitis B DNA test results, so all viral loads for hepatitis B.

In terms of the rule-making process, the Board of Health approved publication of proposed rules on September 12, 2017.

There was a public hearing held on October 25, 2017. We've received no comments regarding the CRE proposal, so no changes were made since we've heard no feedback. We've received two written comments on the hepatitis B proposal, and based on those comments, we have made one change to the proposal.

So first we will talk about carbapenem-resistant Enterobacteriaceae, or CRE, reporting. To remind you, CRE are a group of bacteria that are difficult to treat because they are resistant to many antibiotics.

Infections that are caused by CRE are more frequently found in hospitals, nursing homes, and other healthcare settings. In 2015, there were over 1700 cases of CRE infection in New York City reported to the CDC.

The CDC has, in fact, designated CRE as an urgent threat. That's the highest threat level that's listed, antibiotic-resistant threats, in the United States. This is just to impress

upon you the very significant impact of this infection on human health.

So to respond to that, mandatory reporting of CRE by laboratories is what we are requesting in this amendment. It will assist us in identification of resistant strains, clusters, and outbreaks of CRE. It will also enable us, the Health Department, to ensure appropriate infection-control precautions at healthcare facilities and provide appropriate technical assistance when necessary.

Moving on to our second proposal, hepatitis B DNA test reporting. So we know that in New York City there are about 100,000 New Yorkers living with chronic hepatitis B. Hep B could lead to serious health issues, including cirrhosis and liver cancer.

Hepatitis B DNA tests are important in measuring amounts of virus in blood, or viral load, and they provide important information regarding infectiousness, treatment eligibility,

risk for development of liver cancer, and also treatment outcomes.

Our amendment that we are discussing today is amending the Health Code to require the reporting of all hepatitis B DNA test results, including negatives and indeterminate results. So currently, we are only seeing positive results that are being reported, meaning we don't really have a denominator to our numerator.

This enables the Health Department to identify gaps in access to care and develop target interventions to increase provider knowledge and linkage to care to decrease HBV-related morbidity and mortality.

I will give you a summary of the two comments that we received. The first, from a blood center, requesting that blood centers be exempt from the rule, noting that potentially hundreds of thousands of tests would be e-reported, and that current reporting of policy results meet public health needs.

So we agreed with this, and our response was that in the proposed amendment we've modified that to exempt blood bank laboratories and other laboratories that perform hep B testing on donated blood from the requirement of reporting these negative and indeterminate hep B DNA test results for such donated blood.

The second comment we got was from a laboratory that provides testing for end-stage renal disease patients. They requested that such laboratories with end-stage renal disease patients be exempt from this reporting, and asserted that end-stage renal disease patients are in care and this public health rationale does not apply.

So the lesson from other infections is, just because you are in care, doesn't mean that you are necessarily treated. So we think that the end-stage renal disease patients with chronic hep B should continue to be a part of this reporting structure and that the

reporting of negative results would allow us to better target strategies so that these individuals are actually not only in care, but are also accessing interventions that bring them to treatment as is necessary based on guidelines.

That is the end of our presentation.

DR. BASSETT: Thank you, Dr. Daskalakis. The presentation is now open for questions and the proposal.

DR. KLITZMAN: (Indicating.)

DR. BASSETT: Dr. Klitzman.

DR. KLITZMAN: Thank you. I think this is important stuff for it. I just had a question. What triggers CRE testing?

DR. DASKALAKIS: So, usually, generally speaking, if there is a bacterium coming from a site that should be sterile, when that bacterium is grown in culture, the next response is to get susceptibility testing.

So CRE, there's not -- well, actually, there is a little bit of a

specific CRE test, but it's really done in response to the pattern of resistance that you see in routine resistance testing. So if someone grows E. coli and it's resistant to imipenem, which is a carbapenem, it then qualifies as being a CRE. So it's done on routine testing.

So one of the things that will also be interesting to this kind of thing, as well, is that we don't really know the burden of this in outpatients. So I think that we'll also have a sense of what's going on with those who, let's say, will have a urinary tract infection. They grow E. coli, and now we'll be able to actually see what the burden is from the outpatient universe, as well as what we already know is a significant burden in-patient.

There are some specific molecular tests that are done for carbapenem resistance as well. But usually, to kind of get a sense of what's happening, a standard antibiogram is good enough.

DR. KLITZMAN: Thank you.

DR. DASKALAKIS: You're welcome.

DR. FORMAN: (Indicating.)

DR. BASSETT: Dr. Forman.

DR. FORMAN: Thank you. Just a quick question. I thought I understood it was the laboratories that would provide the results, both negative and positive, here. So what is really the burden on a dialysis center?

DR. DASKALAKIS: Great question. I think with the lab inlay, I don't know the detail, but I do have a comment. I think that they are just concerned that there's going to be a lot of negative reporting. There may be, but I don't know what the burden really would be.

DR. RICHARDSON: I think I can shed some light on this. So dialysis centers, when they have a patient new to them, routinely perform this testing because they do not want to contaminate their machines. So there are machines that are designated for people who are positive and people who are negative.

So they routinely do a lot of

hepatitis testing. But I have to say I do support the Department's approach. I've seen a lot of patients in the emergency department with end-stage renal disease, and although they certainly are in care for their renal issues, many of them do seem to have gaps in care for other conditions. And it may be an important population to track exposures and treatments. But they do perform a large number of these tests on patients prior to dialysis.

DR. DASKALAKIS: Again, the other comment -- thank you very much -- it is electronic lab reporting. So the burden is sort of elusory. It happens for them automatically, for the most part, so I'm not sure what the burden of complaint was. But I think the way that that population potentially being in care, but not necessarily optimally treated, is really important.

DR. BASSETT: Dr. Forman, did you have a follow-up on the matter for clarity?

DR. FORMAN: No. I was just agreeing with what the doctor was just saying. My inclination is to support the Department's proposal here, and I didn't understand what the burden was on dialysis labs. I didn't think they were doing the reporting anyway, and it certainly seems like a population that there clearly are a potential for significant gaps in care and treatment.

DR. BASSETT: Additionally, they are patients who remained in care at that center, which is quite a different situation from a blood bank.

DR. DASKALAKIS: That's right.

DR. RAJU: (Indicating.)

DR. BASSETT: Dr. Raju.

DR. RAJU: Thank you very much. Nice to see you.

DR. DASKALAKIS: Nice to see you too.

DR. RAJU: I just need two clarifications. A CRE is basically an institution-focused disease. It's not a community-based disease. So --

DR. DASKALAKIS: As far as we know.

DR. RAJU: As far as we know, right. So the question is, if they are reporting these things to multiple agencies already, adding one more agency to report to, how does it add value to us? And that is one question on that.

On the hepatitis side, the fact we are going to exempt the blood banks and blood collection agencies included in that, what would be the negative impact on them? So would it send a different message to a different group of people to say, you are exempt, and you are nonexempt? But what is the rationale of exempting them and not other folks?

DR. DASKALAKIS: So on the first issue of CRE, from the perspective of lab reporting, again, the burden is not very high on the lab. It would be electronically reported.

We don't see where clusters are. We don't see where these infections are if we don't have that data. So the CDC, though they may see through the hotline,

a number of CRE infections. Like, New York, since we are on the ground as a local health department, we have the focus in our Bureau of Communicable Diseases on addressing antimicrobial resistance, and having a sense of where this is happening would allow us to focus our technical assistance on other work.

So right now we are sort of getting a number, an aggregate number, and saying there are about 1700 CREs in New York City. But we don't really know the resolution that we would need for intervention. Does that make sense?

DR. RAJU: Okay.

DR. DASKALAKIS: The second question about why the blood banks should be exempt from this, I think it does have to do with the fact that it's hard to formulate a response. Like, some sort of implemented program or some kind of implementation -- implement-able intervention where people who are transient, in and out of the service

where they're donating blood, versus if we have people who are linked to care, we are actually able to identify where they are. And just like we are doing with HIV, potentially to come up with strategies to optimize the care where they are.

We also think that, in general, for them, I think that the folks who will donate blood are going to be a little bit different than the folks that are going to be sort of connected to care. And we think that the burden that they are describing is not worth their time and efforts to sort of do this.

So I think the bottom line is that the idea of where would you launch the intervention and what bank is very transient sort of people who are coming in, not for testing, but just for donating. And I think that we would be able to have a lot more accuracy sort of focused on to healthcare settings where people are getting viral loads done.

DR. BASSETT: Did you have a

follow-up question Dr. Raju?

DR. RAJU: Them not reporting, the blood-donor sites not reporting, what number of people would we not ever get to know that they have hepatitis B?

DR. DASKALAKIS: I can't estimate a number for that.

DR. RAJU: Is there a number we are missing?

DR. RICHARDSON: They still report positives.

DR. RAJU: Is there a number that we are missing?

DR. RICHARDSON: But they still report positives. They report positives now.

DR. DASKALAKIS: Yes. The positives we'll know, it's just the negatives. So we don't have a denominator for that. So what will happen is we'll always get the positives, they just aren't going to be reporting the many, many, many negatives.

MS. REDLENER: I think that's just an important clarification for this

conversation, is that the positives will still be reported.

DR. DASKALAKIS: Yes, from the blood bank. Correct. Nothing changes.

MS. REDLENER: Their concern was reporting the thousands and thousands of negative results.

DR. DASKALAKIS: That's right. So we'll still know who's there --

MS. REDLENER: But they will be exempt from the negative reporting.

DR. DASKALAKIS: Exactly, correct.

DR. GOWDA: To follow up on the issue with blood banks, my understanding is that the reporting is electronic. So I'm trying to grapple with the burden that we are placing. I understand the rationale; you are saying directing the efforts towards a population that has linkages with that facility so that we can follow up, and you might not have those linkages with blood banks.

But I'm still trying to understand the burden on the facility. If we come across this type of situation in the

future, I think that it would be good to get clarity around that issue.

DR. DASKALAKIS: We will take that comment as one to follow up on. The truth is that from the perspective of, also, volume of negative results coming in to us from the perspective of data management, they pull a lot of negative results that aren't really -- in any direction won't be very helpful to us in general. So I think we're sort of hearing that they don't really want to report and also knowing that the burden of those results coming to us would further complicate our work. I think we are in agreement that it's okay that we don't get them. But comment is taken, and we will explore that further.

DR. BASSETT: I think you're asking the question of, I gather, what should we think about blood test results that come from blood banks? Are we ever interested in getting the whole population reported to us? You are asking us to consider what criteria we

would use. So we will do that.

DR. DASKALAKIS: We will do that.

DR. FORMAN: (Indicating.)

DR. BASSETT: Dr. Forman.

DR. FORMAN: Just following up with that, as pointed out in the comment from the blood bank, you take this approach with hepatitis C, right? You don't get the negative results.

DR. DASKALAKIS: Right.

DR. FORMAN: They have an exemption for that. That is not a problem.

DR. DASKALAKIS: That's correct. So we do have precedent for another hepatitis virus, hep C, that we do not get the negative result. It's internally inconsistent.

DR. BASSETT: Thank you. Are there any other questions or comments?

(No response.)

DR. BASSETT: I would like to thank Ms. Redlener for clarifying that this is really an addition of the reporting of negative results that allows us to see the entire universe of testing.

Well, with that, I would like to thank the Board for its comments and questions and ask that we take a vote. Can I have a motion?

DR. RAJU: (Indicating.)

DR. BASSETT: And a second?

DR. FORMAN: Second.

DR. BASSETT: All in favor, please say yes.

ALL: Yes.

DR. BASSETT: Are there any abstentions, or "no" votes?

(No response.)

DR. BASSETT: No?

(No response.)

DR. BASSETT: The proposal to amend Health Code Articles 11 and 13 pass unanimously. Thank you, Dr. Daskalakis.

DR. DASKALAKIS: Thank you.

DR. BASSETT: The next item of business on the agenda is another proposal for consideration of adoption by the Board. This one gained considerably more public attention than the previous one at both the public

hearing and in terms of written comments.

This is a proposal to amend Article 207 of the General Vital Statistics Provisions regarding birth and death records. I know that you are well-known to the Board, but could you introduce yourself, Dr. Schwartz.

DR. SCHWARTZ: Good morning. My name is Steven Schwartz. I'm the New York City Registrar of Vital Statistics.

Today we are going to discuss the proposed adoption of transferring records -- birth and death records -- to the New York City Department of Records and Information Services.

We had proposed a fixed schedule to transfer birth and death records to DORIS annually. Prior to this proposal, there was no fixed schedule at all for records transfer. So we've been in business a long time, and for the last 200 years that I can remember, we did not have any fixed schedule for transferring records. It was episodic.

So the Department thought it would be a good idea to actually have a fixed schedule. These records, of course, all have interest, both a public health interest and also personal interest, and there are many people who are interested in genealogy as well.

So, what are these records? They are personal records. For birth records, living people. So as a matter of public policy, these are private records. They are not public records. Private means only certain people can review those records. And so they include the demographic information; a registrant's mother and father's names; race; ancestry; education; dates of birth; addresses; birthplace; the confidential medical report of birth; and confidential medical report of death, including cause and manner of death. So this is pretty personal information.

We received a lot of comments, 31 people testified, 18 of whom also

submitted written comments. We had over 5,000 written comments received, about over 3,800 of which were signatures to a petition, all of which were opposed to our proposal.

There were only two commenters who were in favor of the Department's report, and that was our Professional Association, NAPHSIS, and the New York State Department of Health.

So, we listened very carefully and read the comments. We feel there is an opportunity to, in fact, expand access to records. We will discuss that in the next presentation in more detail. But to say that the Department would like to propose an expansion of access to records. So, not the changes of dates we had proposed, 125 years for birth and 75 years for deaths, but more to the point of who can have access to these records, these identifiable records. So that is what we have.

The coming attraction of the next presentation will be essentially

proposing that we expand access to both birth records and death records for certain qualified applicants. So why don't we propose this rule now? As I had said, we do not have a rule now for transferring records on a regular schedule.

We wanted to conform to Model State Vital Statistics Law. We also wanted to ensure that no personally identifiable information of a person becomes public prior to a person's death. Right now, people are living longer. We like that part. We would also like to protect those records for as long as that person is alive.

We also heard loudly and clearly that amateur and professional genealogists have expressed strong interest in accessing these records. So our proposed rule, to recap, is a birth record would become a public record on January 31st of the year following 125 years after the date of birth, and the death record would become a public

record on January 31st on the year following 75 years after the death.

Thank you. That concludes my presentation.

DR. BASSETT: Thank you. Should we go on to the next presentation? Then we will ask questions at the end. Are you going to continue with this presentation, or is there another person presenting?

DR. SCHWARTZ: Only me.

DR. BASSETT: Only you. So we will continue. Thank you.

DR. SCHWARTZ: Thank you.

DR. BASSETT: This presentation will address the ways in which the proposal has been amended in response to public comments. Or it's a completely different -- it's a different change to the Health Code. Okay. Who can have access?

DR. SCHWARTZ: An expansion of access.

DR. BASSETT: An expansion of access, and this was in response to

public comments. Please proceed.

DR. SCHWARTZ: So we have already established that these birth and death records are protected from access to the general public because they contain individually identifiable information, which is considered private. However, they are also historical documents of interest to family members and persons researching their ancestors.

So the department agrees that certain family members should have access to birth and death records prior to the records becoming public. So they are still private, but that entitled applicants, qualified applicants, could have access to them. The new proposed provisions will allow family members to access information while still protecting the confidentiality of vital records through appropriate periods of time.

Currently, birth records are available, upon request, by a person of 18 years of age or older, by a parent or

a legal representative to whom the record of birth relates, by an attorney authorized in writing by a person over 18 years of age, and upon order of a Court of competent jurisdiction. So, those are for births.

Current provisions for accessing death records include accessing by the spouse; domestic partner; parent; child; sibling; grandparent; grandchild of decedent; a legal representative of the estate; a party with a demonstrated property right; a funeral director, in the course of business, accessing that record within 12 months of death; and persons or agencies who otherwise establish that records are necessary or required for judicial or other proper purpose.

So let's move on now to what we are proposing, what we might call new and improved access to birth certificates with proof of death. So these are births where the Department --

(Audio interruption.)

DR. BASSETT: Sorry. Please proceed.

DR. SCHWARTZ: These are birth certificates where the Department would require proof of death, and all of these we're reporting as new. And I say that because we've actually, as matter of practice, been largely doing this. We want to establish this as a uniform practice under the Health Code.

So all of these categories: spouse, domestic partner, parent of a child greater or equal to 18 years of age, a child, sibling, niece, nephew, aunt, uncle, grandchild, great-grandchild, grandniece, grandnephew. All of them, from what we've proposed, would have access to that record of birth if there is a proof of that death.

We are also proposing an expansion of those who have access to death certificates of a decedent. So the ones that are marked with an asterisk are new. So we are proposing to add -- in addition to the spouse, domestic

partner, parent, child, sibling, grandparent, grandchild -- we are proposing to add great-grandchild, great-great-grandchild, nephew, niece, aunt, uncle, grandnephew, and grandniece. That is our proposal for your consideration.

DR. BASSETT: Thank you. The proposals, both proposals, can be considered jointly, I think, but we are going to have to take two votes. If I could just ask you to tell the Board why 125 years was selected.

DR. SCHWARTZ: The 125 years is in the Model State Vital Statistics Act. So it is something that was voted on by all of the states, since vital records are a state function.

So this was a collaboration of the National Center for Health Statistics and our professional association, to come up with what was considered to be a reasonable way of protecting records and making them available after that time, 125 years.

We had a death a few years ago of a 118-year-old. We believe that that 118-year-old person has as much right as anyone else to have her record kept as private. So as the population ages and as our New York City population grows stronger and healthier, we would like to have all of those records protected and we are hoping that 125 years is long enough.

DR. BASSETT: Thank you. We are open now for questions and comments.

DR. KLITZMAN: Thank you, Dr. Schwartz. I had several questions and the first one is, how do you think about step-relations in this era of growing blended families?

DR. SCHWARTZ: Some people would ask that question. We do not permit that, and I'm not aware of any state that does. As a matter of practice and as a matter of proof, how do we actually operationalize that?

DR. KLITZMAN: My next question is, how did you think about how many

generations to go back? I was reading the comments where it seemed that some of the commenters were several generations removed. And I see in the case of great-grandchild, that's going four generations back. In the case of a grandniece or nephew, that's going three generations back. So can you share with us how you thought about that issue?

DR. SCHWARTZ: Well, we looked at the comments; we considered them. It is, also, how does somebody prove a relationship? We are essentially going to accept somebody's -- an applicant's representation. So we think this is long enough. That is enough generations and for a purposeful use of this. And this will be subject to public comment, and we would learn from that and listen.

MR. MERRILL: I'll just to point out that it was degrees of contiguity, the same steps out. Also, at some point they are going to become public to everyone in 125 years, so it wouldn't make sense to go --

DR. KLITZMAN: Yes. Just quickly -- I just had two more quick questions. Can you speak about what the process would be for researchers or some of the categories who testified, professional genealogists, family genealogists, for obtaining records if they didn't fall into one of these categories.

DR. SCHWARTZ: We work with them all the time today. But the genealogist, him or herself, does not have an authority or a right to get the record, but they may hire somebody. That is, a family member may hire somebody to do it. So then they can authorize so that that family member, who is a qualified applicant, can allow the access.

DR. KLITZMAN: It would be the same as a qualified representative; is that correct?

DR. SCHWARTZ: They would have to have written authorization in the same way an attorney would, where an attorney can act in someone's stead.

DR. KLITZMAN: My last question is,

several commenters referred to other states that have more liberal or shorter timeframes for releasing records. Can you share with us how you thought about coming up with these years? I know you referred to the model regulations, but I'm sure you also looked at other states that have shorter timeframes. What was your thinking there?

DR. SCHWARTZ: So there are still states that have open records, totally open records where anybody can get anybody's records. Vermont just recently, I think in the last year, closed its records. That was a completely open-records state.

It's a challenge because we have 57 vital records jurisdictions, and they each have their own legislatures, as well as boards of health, and they make a decision, and sometimes that decision is not based on all the evidence. So we did a survey; we talked to people.

We feel that what we have proposed is the right thing to do, especially

with providing greater access to the categories of entitled applicants, that that will really make it work, and therefore keeping our private records private, with greater access to authorized applicants.

MS. REDLENER: (Indicating.)

DR. BASSETT: Ms. Redlener.

MS. REDLENER: I must say that I was very impressed with the number of comments, both written and in person, and I learned a lot about this topic. So I have a couple of questions, based on some of the comments, that I think will add some clarity.

The Model Vital Statistics Act, which you mentioned, I think, was implemented or voted on in 2011, one of the individuals who commented said that that Act was put on hold in 2012 and not really implemented by any or many states at all. I'm just wondering about your perspective on that.

DR. SCHWARTZ: This may surprise people, but vital records to state

legislatures are not always their highest priority. So it's not necessarily something that gets brought to the floor when there is a legislative session, and for most states, they are relying on state legislatures to pass these laws.

We are really lucky because New York City has a Board of Health, which has enabled us in many ways to act very quickly because of the opportunity of having that Board. So one thing is it's just not the highest priority in legislative agendas, and it's also pretty long. The Model State Vital Statistics Act is some 70 pages, hard to get that through.

One other thing came up with The Model State Vital Statistics Act where it had been normally approved by the secretary of HHS. In this case, it wasn't, and the stated reason was that they didn't want to address the transgender issue.

MS. REDLENER: Okay. Thank you. I

have a couple of other questions just for clarity. Also, another presenter mentioned that the U.S. Department of HHS in 2013 established 50 years as post-death accessibility.

Is that something that we are considering? Is that true? I'm going by the folks who commented.

DR. SCHWARTZ: I'm not aware of that.

MS. REDLENER: It's in the comments.

DR. SCHWARTZ: I'm not aware of that.

MS. REDLENER: Okay. The last thing, and I'm really just trying to understand how New York City fits within the country and the guidelines that are implemented. I don't necessarily think, from my perspective, that we need to be the strictest in the country. I think there are balancing factors to consider.

So I read, I think in the initial proposal that you made in September, that we were also looking to be in alignment with New York State

guidelines. But as I read the documents, I believe New York State recommends 75 years for birth records and 50 years for death records. Is that accurate?

DR. SCHWARTZ: Yes, it is.

MS. REDLENER: So we are not proposing to be in alignment with New York State. We are proposing to be stricter than New York State at this point.

DR. SCHWARTZ: Our understanding, in discussions with New York State, is they are looking to be in alignment with New York City's proposal, though it has not been addressed yet.

MS. REDLENER: I think the other question, if I may, thank you. I found it interesting, and I don't know how to assess the accuracy of the presentations, but from the various credible societies, representatives were saying that there really hasn't been much evidence of identity theft using birth and death records.

That identity theft is more -- especially now in the age of the internet and cyber issues, there are other ways that people are much more likely to get information about people that would lend itself to identity theft.

Then there was one chart that was entered into the testimony that showed states, how strict they were, versus the number of identity thefts per 100,000 thousand people, and it was a fairly straight line. Whether you were strict or lenient, it didn't seem to affect the identity thefts that could be attributed to birth and death records. Is that something that -- is your sense of information accurate?

DR. SCHWARTZ: I remember reading that too. And many people in the comments and in the public hearing, they raised issue and said, "Make all records public. We don't care. It's already out there on the internet. Everybody can get everybody's record already."

Well, I don't know how many people, if they were given a choice of having their records kept confidential or not -- I'm not going to do a poll here -- but how many people would really want to have their records completely open, including Social Security numbers?

MS. REDLENER: I don't think people, at least certainly not all people, are recommending just having records available. It's just a question of the benefit and the risk and weighing the length of time that we are restricting records, which is important for all of these reasons that I found in here.

It's interesting just to read about how many people's ancestors came through New York City, and the records in our City relate to not just New York City residents but immigrant populations around the country.

So I do feel we have a responsibility to consider the genealogical and the personal and the historical benefits to making some

records available. I am certainly not wanting to swing the pendulum to all records, all the time. But from my perspective, protecting a 108-year-old by going to 125 years is too extreme.

It seems that there are a number of states that either recommend birth records being available at 75 and death records being available at a 50 years, or maybe birth records 100 years. I'm just saying that from what I hear here, and I know it is a perspective, it's from a genealogical perspective, that perhaps we are going a little too extreme in how we restrict the records. I'm sorry. I had one more different question.

DR. BASSETT: Okay. Then we will open up for other comments from the Board. These are all good questions by the way.

MS. REDLENER: Sorry. I'm just wondering how difficult it is and what the process would be for family members, in your proposal, to get information.

What is the process? Do you have to apply? Do you have to certify? How long does it take? I'm just wondering how that works now.

DR. SCHWARTZ: We are very fast, so people can walk into our office and walk out with a record the same day. We can't do faster than that.

MS. REDLENER: That is impressive. Thank you.

DR. SCHWARTZ: So we issue about 800,000 certified copies of birth and death records a year. That's the retail side of our business.

DR. FORMAN: (Indicating.)

DR. BASSETT: Dr. Forman.

DR. FORMAN: Dr. Schwartz, thank you very much. I was sorry to miss your presentation of our president, Alexander Hamilton, last time, but I did read it.

I also was fascinated by this topic, reading through all comments and reading through the discussion last time, and I've been thinking about it a lot. And it seems to me that this is really an

exercise in balancing the needs for access to this information between these authorized or appropriate individuals, which is family versus non-family, historians -- genealogists and historians that are not related to individual who is trying to get that information.

On balance, it feels like this compromise, which expands, fairly dramatically, access to related individuals is well-thought out. I think this seems to really expand the access to many other people who may be related. Although I had a specific comment about formal adoption, which I can come back to. But that seems to me to address many of the important concerns, leaving, then, the concerns about access to non-related individuals for historical purposes.

There was a big focus on what are the downsides, and I read about the three states that were highlighted. California, who releases non-certified

records, which doesn't seem to make much sense to me, Vermont, which may have changed its rules, and Massachusetts.

But it's not just identity theft. There are other misuses of that information that would not be captured in that sort of analysis. I can think of employers, health insurers, lots of reasons why people might not want information contained in these records to be released that are not just identity theft.

So as I have thought about it, I have come down a little more on the side of wanting to protect people's privacy and less so on the value of genealogy to historians, which is the work of genealogists that's beyond what they do for an individual who's a qualified applicant. So, overall, I think I support this compromise, and the years that were proposed, with a dramatic increase in access to individuals. I just wanted to throw that out there.

My specific question about adoption

is, if two individuals formally adopt a child, will that person's children and grandchildren be captured by this? In other words, if I adopt somebody and 50 years from now, will their children and grandchildren be eligible to apply for my information through the vital statistics?

DR. SCHWARTZ: That is a big question. The formal process that vital records engages in is that the original record, the original birth record, is placed under seal and the new -- the adoptive parents are placed on the new record. So that's the only information that we can provide.

MR. MERRILL: I want to jump in here. The second proposal is being proposed for public comment. So adoption is an interesting issue, and I think somebody raised "steps" earlier. And I think that those are things that we can hear comment on and consider before we vote.

DR. BASSETT: I thought it was

appropriate to discuss these together because they are linked. In many ways, the proposal that we are being asked to consider for publication is the response to comments about access, limitations that will develop because of the age limits, the years that are being proposed. It's the proposal on 125 years after birth and 75 years after death that we are going to ask you to take a vote on today.

If I could just ask one clarifying question, are there any jurisdictions that use these type of age ranges? For example, that kind of age after birth, 125 after birth, for access to a birth record. Are there any jurisdictions, or will we be the first?

DR. SCHWARTZ: Some states actually --

DR. BASSETT: I mean anywhere. Canada, for example.

DR. SCHWARTZ: Some states do not open their records ever.

DR. BASSETT: That is longer than

125 years.

DR. FORMAN: (Indicating.)

DR. BASSETT: Dr. Forman.

DR. FORMAN: I'm sorry. Thank you. I just had one other point to bring up, which is in the previous discussion of last September, in the comments it was also noted that once the records are transferred to DORIS, you no longer have the ability to modify them, which seemed to me to be important. And certainly, if you talked about an open-records state where they are immediately transferred, that would seem very problematic, given the number of modifications you make to these records and how important that can be, even many decades later.

I think there was description of an elderly individual who asked to have his birth record modified, and it was a very important thing for that individual. And once it's released to DORIS, you no longer had the ability to do that. That is another compelling reason to consider

maintaining the privacy and control of these records.

DR. BASSETT: Dr. Raju, did you have a question? Then Dr. Klitzman.

DR. RAJU: I concur with my colleagues that it makes very interesting reading, and I learned a lot about this by reading through these comments. In my opinion, it really falls to the three different categories who really feel very nervous about this.

The first group is a group of people with genuine family members who really want to know their ancestry and they want to really find out that ancestry. Your proposal basically kind of gives them an opportunity to do that. There is not an issue with that.

The second one is the commercial business interest. There are companies which basically do this research for you, and they would like to have an open way of doing that. Their whole business model depends on having records open so that they can really do this work.

I'm not very concerned about that. That's a business interest. It's not really any particular individual interest. To me, individual interest is definitely more important than the business interests of a group.

The last one is a group, which we don't -- we give access, but we don't yet, is real researchers who really want to do some research into these topics so that they contribute something to scientific work, which we learned from the genealogy.

We need to figure out how we could do that. It could be like we have the IRB and the things to be able to get somewhere in doing that, as opposed to doing -- so I don't see a major issue with this, because I can see a tremendous amount of people are worried about things, but I believe that you do give them an equal opportunity. If you are really interested in learning from answers, then there is a method to do that.

If you really want to do research for the public good, then there must be a method of doing that. For the commercial interests of basically trying to do this thing to make money, I really have no major interest to support that as an individual. So that's my comment on this.

DR. BASSETT: Thank you, Dr. Raju. Do you want to make a comment?

DR. KLITZMAN: I have a comment and a question, really for my colleagues. And I also wanted to just appreciate all the work that you and your Department have obviously put into this, in considering all the comments and trying to respond in a way, to paraphrase Dr. Forman, that balances the interest of privacy and public good, as we always try to do.

My question for my colleagues is, given the interest that this has generated, given the nuances, do we feel like we can vote today on the first one, before hearing comments and possible

provisions to the second one?

DR. BASSETT: The second vote would just be to post the proposal for public comment, and it obviously is then subject to revisions. Many of the questions addressed by the Board are really considered as part of the public comment period.

DR. KLITZMAN: That's the point. I think --

MR. MERRILL: (Inaudible.)

DR. BASSETT: Oh, I see. Yes, please. Any comments?

DR. FORMAN: (Indicating.)

DR. BASSETT: Dr. Forman.

DR. FORMAN: Yes. So my response to that would be that even setting a schedule of 50 years after -- sorry, 75 years after death and 125 years after birth is an improvement from what we currently have, which is there is no schedule. There is absolutely no plan right now. So at the moment nothing is moving, unless you come to the Board and say, "We would like to, on this one

auth., release certain records."

So I would support voting on this today for approval because it is a step forward, and at least that's a bar to move from. People could come back, you could come back, and say, "We've decided it's too long. We want to change it." But right now, there's no schedule at all, so this at least sets the schedule.

I have confidence in the process of public comment and this Board to then address, in the near three months, the question of expanded access for people who really should have access.

DR. BASSETT: I think -- is the question, just so I understand Dr. Klitzman's comment -- but I think she's saying that if you are talking about these as a package, we should vote on them as a package. Is that basically your argument?

DR. KLITZMAN: Yes. Given the number and depth of comments on the first one, I'm just asking my colleagues whether it would make more sense until

we hear comments on the second before voting on them. So, again, I want to hear what my colleagues think, and based on that, possibly proposing voting on them together.

DR. BASSETT: We have heard from Dr. Forman, and he is prepared to vote on the 125/75.

DR. RICHARDSON: I'm prepared to vote today. I appreciate the work on expanded access, and I look forward to the public comment on that. But I want to reemphasize Dr. Forman's point that the situation right now is that there are records, which, I presume, which are more than 125 years since birth and 75 years since death, which will not be released until we act on this.

So I'm not sure why those of you who are supporting more openness want to delay action on this one pending a related, but separate, issue on expanded access to those who are related. So I'm prepared to vote, and I would favor voting now so that next time we can

focus on the expansion for relatives, as opposed to revisiting this entire conversation again.

DR. RAJU: I agree with both of them, so I'm willing to vote on it today.

MS. NAYOWITH: As am I.

MS. REDLENER: I would just like to note that the last time the records were released was 108 years ago for birth records and 68 years ago for death records. So we are under the threshold of what we are voting for, so we don't have to worry about not releasing older records, but I feel --

DR. RICHARDSON: That may be the release, but there may be records that were not released at that time which now are over this limit. It's just a math issue.

DR. BASSETT: I'm not quite sure. I'll look for guidance from the general counsel. But I think we'd better hear from everybody on whether or not they want to have a motion entertained.

MS. REDLENER: I do not want to vote on this without the amendment.

MR. MERRILL: Do we have a motion?

DR. BASSETT: Not yet. We have Dr. Raju to --

DR. RAJU: I am willing to vote on it today.

MS. NAYOWITH: As am I.

DR. BASSETT: All right.

DR. GOWDA: I am as well. I am ready to vote on it.

DR. CARO: I am ready to vote.

DR. BASSETT: All right. Can I get some guidance from the general counsel?

MR. MERRILL: I think we can take a vote on this.

DR. BASSETT: All right. Then I'm going to ask for a motion to vote on the amendment. Move for approval of Number 3, that is the Notice of Adoption to amend Article 207. This is the Notice that was published in the City Record on September 20th.

DR. RICHARDSON: Move to approve.

DR. FORMAN: Second.

DR. BASSETT: All right. So let's have all in favor say yes.

MS. NAYOWITH: Yes.

DR. CARO: Yes.

DR. RAJU: Yes.

DR. FORMAN: (Indicating.)

DR. GOWDA: (Indicating.)

DR. RICHARDSON: (Indicating.)

MR. MERRILL: So, six.

DR. BASSETT: All against?

MS. REDLENER: (Indicating.)

DR. BASSETT: One. And then any abstentions?

DR. KLITZMAN: (Indicating.)

DR. BASSETT: Two -- one. All right. So the motion carries with one "no" vote and one abstention. The remainder are "yes" votes. Thank you.

Okay. Now we need to move on to the question of the Proposed Resolution to amend Article 207. This is the amendment that we've devoted most of our conversation to about extended access to birth and death records.

DR. RICHARDSON: Move for approval

of publication.

DR. BASSETT: A second?

MS. NAYOWITH: (Indicating.)

DR. BASSETT: May I have all in favor please say yes?

ALL: Yes.

DR. BASSETT: All opposed?

(No response.)

DR. BASSETT: Any abstentions?

(No response.)

DR. BASSETT: This motion passes unanimously and is approved for publication. Thank you, Dr. Schwartz.

We will move on to Item Number 5 on the agenda, which is a proposed resolution to amend Article 43. These regulate school-based programs for children between the ages of three and five. Do we have a presentation on this matter?

MS. SCHIFF: (Indicating.)

DR. BASSETT: Thank you. If you can identify yourself for the record.

MS. SCHIFF: Good morning. I'm Corinne Schiff, Deputy Commissioner for

Environmental Health. I'm here with Dr. George Askew, Deputy Commissioner for Family and Child Health, and Monica Pollock, Acting Assistant Commissioner, Bureau of Child Care. We are here with proposals to amend Article 47 and Article 43.

First, as a reminder, Article 47 covers center-based childcare and shelter-based drop-off care, and Article 43 addresses school-based programs for children ages 3 to 5. I'll start by going over the proposed amendments to Article 47. We're really proposing four categories of amendments.

First, to clarify certain provisions, and we are doing this essentially to facilitate compliance by childcare providers. Most of the changes are not substantive. We are adding some definitions and we are proposing some language for specificity, and I will review the notable, proposed changes.

Next, we have a proposal to require

once-daily toothbrushing, to require epinephrine auto-injectors on site, and enhance training requirements.

First, some of the notable new definitions that we are proposing. We are proposing to add a definition for competent supervision, and that the definition is that it would require direct observation, for children to be within the line of sight, and that supervision cannot be conducted by mechanical, audio, or video device. A teacher has to be physically present in the classroom. The teacher has to be near enough to respond to children when they need it, and that supervision takes into account the child's age, emotional, physical, and cognitive development.

Next, we are proposing to add a definition for corporal punishment. Corporal punishment is already prohibited under Article 47, but there's no definition for that. We are proposing a definition here that tracks the New York State definition. I won't

read you that long list, but those are all behaviors that are inappropriate for teachers to use with young children.

We are proposing adding some additional detail in certain parts of the Article. First, to make clear that the maximum number of children on the premises includes all children who are present, even if those children are not enrolled. So, for example, if a teacher brings a neighbor's child or a grandchild to work that day, that child counts towards the maximum number of children. Next, we would make clear that the maximum group size per room means the room or a physically separated space.

DR. BASSETT: Dr. Askew, if you can identify yourself for the record.

DR. ASKEW: Absolutely. Dr. George Askew, Deputy Commissioner for the Division of Family and Child Health. I want to thank you. I appreciate the opportunity to present something, which on the face of it -- and no pun

intended -- seems rather simple and mundane, but, in fact, can be life-changing and even life-saving for children.

So why a toothbrushing mandate in childcare? Tooth decay or caries, is the most common, chronic disease in childhood. But it is preventable, and relatively easily so, with simple measures like toothbrushing.

Having caries could lead to a higher risk of developing additional caries; difficulty eating and speaking; hospitalizations and emergency room visits; greater risk for delayed physical growth or development; and clearly, because you either can't eat well or you're sick, you miss time in school.

The American Dental Association recommends brushing twice a day at the erection of the first tooth, which is usually around six months. We know in the pediatric field it's called first tooth, first year, and that's the time

we're supposed to recommend children actually see the dentist for the first time, sometime in that period.

The Department's 2014 Child Dental Health Survey showed that at least 15 percent of children in New York City Child Care Programs experience dental caries. The percentage goes up to over 40 percent in third grade. This is compared to about one quarter of preschoolers nationally.

Despite the established benefits of toothbrushing, the oral hygiene practices of young children in New York City remain inadequate. According to the same study, 40 percent of children age 0 to 6 years old brush their teeth only once a day or less, and 45 percent of children ages 0 to 2 did not use fluoridated toothpaste.

Our oral health program conducted a survey to determine risk and protective barriers of tooth decay among children in New York City group daycare centers with over 1800 parents and caregivers,

and 67 daycare centers reported risk and protective factors for tooth decay of their children and themselves. So we know this is an area we can and should do more.

Of course there is a tactical on change of behavior toothbrushing as part of the requirements for the Federal Head Start Program. It has led to children in New York City's Early Learning Programs being two and a half times more likely to brush twice per day than children in other programs. So this clearly sets children up for a lifetime of good oral health habits.

The Department is proposing to mandate that child care programs and family shelter-based child supervision programs assist children age 2 or older with brushing their teeth at least once a day.

We are proposing that they provide the child with individually labeled, child-sized, soft-bristled toothbrushes, fluoridated toothpaste with the American

Dental Association's seal of approval; the staff must be trained in proper toothbrushing technique, demonstrate proper toothbrushing techniques to children, keep a log of the date and time and the staff lead on toothbrushing, rinse toothbrushes individually or enable children to rinse toothbrushes, and store the toothbrushes in a sanitary manner, as is mentioned: rinse under water, store in open air not touching or dripping on each other or touching any other surface. Parents may opt out of this mandate with a signed, written request.

MS. SCHIFF: Next, the Department is proposing a mandate regarding epinephrine auto-injectors. It's estimated that four to six percent of children nationally have a food allergy, and some of those food allergies are life-threatening.

The Epinephrine Auto-Injector is an easy-to-use, life-saving device. Although we don't have data, the

Department's experience teaches that some children with life-threatening food allergies may not have the auto-injector with them in childcare. And that some children have life-threatening food allergies that are identified for the first time in care.

In 2016, New York State amended public health law to allow a childcare provider, among other entities, to obtain a non-patient specific epinephrine auto-injector. So this gives the opportunity to have life-saving medication available in childcare.

The proposed program is to require childcare providers to keep two non-expired auto-injectors on site. It comes, really, two to a package. The auto-injector would have to be stored so that it is inaccessible to children, but readily accessible to staff in case of an emergency, and it has to be at the appropriate dose.

There would need to be a staff

person trained to use it on-site whenever children are present. So we would leave it up to the program to determine how many people they need to train to meet that requirement, and the training has to be by a nationally-recognized or New York State-approved provider. Those are the elements of the training program, and that tracks the New York State Public Health Law.

The program would include in it a safety plan. Article 47 already has a requirement for a safety plan, so this would update safety plan requirements to include details about storage, checking on the expiration of the auto-injector, and for training.

And should there need to be an administration of the auto-injector, the rule would specify that after that administration there would need to be a call to 911, which follows the packaging instructions. But we wanted to emphasize that by placing that in the

rule as well. There would need to be notification to the parent or guardian immediately, entry into the medication log, and then notification to the Department within 24 hours.

Next, we are making some proposals regarding training. There are three areas of training proposals. One is to establish uniformity of training requirements. The code currently requires certain training for certain staff, and the proposed trainings all address what we see as fundamental competencies that are valuable for all staff.

Expanding training promotes high-quality, safe childcare, and creating uniformity recognizes that this is a relatively fluid workforce. And so as staff move from one program to another, it promotes compliance if everyone has gone through the same training.

The addition of certain trainings would be to fulfill professional

development gaps that we see in the code, and also to align with new federal childcare development block grant requirements. Those apply to federally-funded programs, but they also suggest a baseline appropriate standard for all childcare programs.

There are a couple of trainings we are proposing to require be fulfilled sooner, upon hire. And I wanted to note, before I get into the details, that the trainings are readily available. So first, the trainings for uniformity. I won't go through all of these. You can see them here, and they were in the proposal, but these were trainings that are currently required only for assistant teachers. You can see that they are really fundamental for caring for young children.

Next, the Board required, in September, certain trainings for shelter-based staff. We think these are important trainings for all childcare staff. Then there are trainings that

are currently required only for night staff or infant-toddler programs, that we suggest are appropriate for everybody.

There are a couple of additional trainings that we are proposing. First is enhancement of emergency preparedness, and that would be relating to natural disasters and violent events.

Then, also, training regarding allergic reactions. So the scheme would be that everybody in the childcare program would be trained in allergic reactions, and then select staff would be trained specifically on the administration of the epinephrine auto-injector.

Regarding CPR and first aid, Article 47 already requires that there be at least one person trained and certified on site whenever children are present. We would update that requirement to say that the training and certification to be pediatric CPR and first aid, and should have a hands-on component. We

would propose to apply that to new and to renew old permits, so that would kind of roll out.

Then, as I mentioned earlier, we are proposing to change some timing requirements. Right now, the timing for child abuse and maltreatment is that a staff person needs to be trained within the first six months of a start date. We think this is very important training and want to move the timing up to three months.

Infection control and emergency procedures, we think, are also fundamental trainings. Right now, there's no specified timeline, so we would make those within three months of the start date. And we would make clear, again recognizing the fluidity in the workforce, that the training is transferable from one program to the next.

Then we made some proposed adjustments for the Board in September, added provisions for shelter-based

drop-off care, and you may recall there was discussion about accreditation and that we had not been consistent in the proposal at that time. So we have updated the language, we think, to address the concerns that were raised by the Board at that time.

In the September meeting, you asked us to get back to you with an update. So I'm happy to report that out of the 33 possible drop-off sites, 25 are already in the permitting process; five have no secondary egress, so those were not eligible; three didn't apply; and there were three additional sites under construction hoping to become drop-off sites. That is it -- oh. No. Sorry.

So that was addressing Article 47, the main proposals are the same for Article 43, the proposal to add the once daily toothbrushing, maintenance of an epinephrine auto-injector, and the training requirements. We can take questions.

DR. BASSETT: Thank you to the

presenters. So this is a fairly expansive addressing of Articles 43 and 47. Let's try and keep the conversation orderly by talking about it in the order that it was presented to us.

The first was the clarification to facilitate compliance, things about line of sight, supervision, and so on. Are there any comments or questions about that?

MS. NAYOWITH: I just think generally that the safety, health, and well-being consistency is much appreciated. I also want to acknowledge the fact that there will be shifts in the administration of childcare in the City now. And so it's useful to have consistency across programs as the childcare programs move from ACS to the Department of Education. So I appreciate these very much.

DR. BASSETT: Okay. Thank you. Then shall we move on to the discussion of toothbrushing, or did you have a comment?

DR. RAJU: One comment. These training requirements are ongoing, or is it just once you get trained and that's it, you could keep it for life?

DR. BASSETT: Well, that was the fourth part of the presentation. So can we just see if anybody has any comments on toothbrushing?

DR. FORMAN: (Indicating.)

DR. BASSETT: Dr. Forman. I saw a lot of hands up.

DR. FORMAN: Thank you. This is an interesting proposal. I certainly agree with the importance of dental hygiene, preventing caries, as a critical public health issue for young kids, without a doubt. But I am struck by the potential challenges, logistically, of implementing this. I'm just imagining these preschool classrooms with kids and toothbrushes and water, and having worked with young kids a lot, it seems challenging. I'm sure a lot of this will be discussed when this is published for comment, presuming we approve it and

there is public comment.

But I wanted to ask about the New York City Early Learning Programs that were mentioned, which seemed to imply that this is successfully implemented in a certain category of early childhood education programs that are under federal regulation that ask for this.

So I just wanted to hear, how does it work? Is there a model for making this work? I could just imagine kids sharing toothbrushes and all of the other risks that come.

DR. ASKEW: Absolutely. It works, and it works quite well, and it's been working for many, many years. I was actually the pediatrician of the Head Start Program back in 2000, and it was already being implemented then as part of the program standards for Head Start.

We actually went out and we visited programs that do the practice. It's very simple. It's not very burdensome. It takes ten minutes or less from actually going from getting the

toothbrushes together, getting the toothbrushes loaded with toothpaste, brushing the teeth, and then back into their storage area. So it's much simpler than you might imagine.

DR. FORMAN: And there's a lot of those programs, right?

DR. ASKEW: There's a lot of those programs. Well, Head Start services about a million kids across the country.

DR. GOWDA: (Indicating.)

DR. BASSETT: Dr. Gowda.

DR. GOWDA: I want to thank you for that presentation and for your hard work. This is really, I think, fantastic, to be in the Department of Health, who is doing this great work.

My questions were also about the logistical nature of the toothbrushing, and the same concern about do we have any guidelines to prevent sharing of toothbrushes, number one? And number two, what is known about the risks of communicable diseases?

I know it has been established that

this work has been done with over one million kids, as you mentioned. Has there been any research on what the risks are for communicable diseases, if there is sharing of toothbrushes?

DR. ASKEW: As part of the mandate, each child will have to have their own toothbrush that will be labeled for each child. From what I understand and know, the sharing of toothbrushes, once you've done that, it's not much of a risk with respect to communicable diseases.

I have not seen any published data around communicable diseases being spread through toothbrushing practices, but that's just to say that I'm not aware of it. It may be, in fact, true. Actually, my (indicating) --

DR. RUBEN: We haven't come across any literature on communicable diseases related to this.

DR. BASSETT: I need to ask you identify yourself for the record.

DR. RUBEN: I'm Thalia Ruben, dentist here at the Department of

Health.

DR. BASSETT: Thank you.

DR. GOWDA: I want to thank you. It would be nice, when you come back to the Board, to present that data to us, if you do have them.

DR. ASKEW: Absolutely.

DR. BASSETT: Dr. Richardson.

DR. RICHARDSON: Again, echoing my colleagues, thank you all. The standardization and consistency you are proposing, I think, really is a huge step forward. I guess I want to probe a little bit more. I am reassured to hear about these Head Start Programs where this has been done successfully.

One of my major questions was about the length of time this would take. I'm the mother of two, and I couldn't get the two of them with their teeth brushed in ten minutes. So is there some differences in the staffing ratios in the Head Start Programs you are describing, and what's typical in childcare centers? Because I can see

this becoming, in addition to the concerns about sharing of toothbrushes, quite an onerous process that takes up some portion of the day that might better be served.

It's been my observation that not all two-year-olds enjoy having their teeth brushed. So I do think there are some trade-offs to proposing this, and I understand all of the benefits. But I guess I would like to hear a little bit more about reassurances that this isn't going to become problematic.

DR. ASKEW: This is like anything else that you are introducing to infants and toddlers. You are right, that is a challenging age. But what we find with toothbrushing is that this is actually a wonderful transition activity in childcare as well. So you can combine it with a singing activity. You can make it part of a transition. You can use it as such.

So, again, it's opportunity. It actually provides an opportunity for the

providers. One of the things that's very difficult in childcare programs is transitional activities, and this is wonderful and actually serves a very important purpose.

DR. BASSETT: Thank you. I think --

MS. REDLENER: (Indicating.)

DR. BASSETT: Ms. Redlener, please.

MS. REDLENER: Thank you. I certainly --

DR. ASKEW: I know you like toothbrushing.

MS. REDLENER: I certainly endorse the early introduction and consistency of toothbrushing in children, and it's interesting to see that it has long-term effects.

My one question is engaging parents or somehow incorporating -- making sure that parents are aware that this is a process that they can do at home. That it's not just the responsibility of the childcare facility, that they should be aware of the goals and reasons for why we are doing it. You know, just a

little parent education complement to the new activity.

DR. ASKEW: Absolutely, and I'm sure that will come through in our guidelines. And clearly, toothbrushing in childcare leads to greater toothbrushing at home, because if you're only doing it once, but you're also seeing that more of those children are having their teeth brushed two times or more throughout the day, clearly it means that parents are getting the message or maybe kids are even asking for them to have their teeth brushed.

MS. REDLENER: Great. Thank you.

DR. BASSETT: Perhaps the last comment, from Dr. Klitzman.

DR. KLITZMAN: Thank you. I'm sure my dentist is very appreciative as my teeth are probably the most expensive part of my body. Anyway, thank you for your excellent work.

My question is, have you yet or what are your plans to engage the regulated community daycare center or childcare

center operators in figuring out the best way to address some of the implementation issues that have been raised?

MS. SCHIFF: Well, first, should the Board approve, the proposal would be open for comments, so we will hear from the providers. The Department will be providing training, and we will be putting out guidance for them and can make recommendations about when they might think about including it in the course of the day, when it might be a little less time consuming.

Children are already sitting around the table eating lunch, that might be the time to then pass around the plates with the little bit of toothpaste and brush right then. So we can make those suggestions; ultimately, it's up to the program. We are not proposing to dictate when it would be, and so every program is going to be different, and it would be up to them to figure out the best time.

DR. BASSETT: Thank you. The next item to discuss is the proposed requirement for epinephrine auto-injectors to be on site. Are there any questions or comments from the Board?

DR. FORMAN: (Indicating.)

DR. RICHARDSON: (Indicating.)

DR. BASSETT: Dr. Forman, Dr. Richardson.

DR. FORMAN: Thank you. Just a very quick one, which is, are there other jurisdictions that require this, and -- actually two -- how has it gone with them? The second is, what does the AAAAI say about this? Do they have a position on this, the American Academy of Allergy, Asthma, and Immunology?

MS. SCHIFF: Our research revealed no other jurisdictions with a mandate for childcare, and we will send the proposal to that professional organization to get their feedback.

DR. FORMAN: That seems to be the professional organization for allergists

and immunologists, and that's where this sort of stuff is often discussed, at national meetings.

DR. BASSETT: Thank you for that comment. Thank you.

MS. REDLENER: (Indicating.)

DR. BASSETT: Dr. Richardson and then Ms. Redlener.

DR. RICHARDSON: Yes. As an emergency physician, I'd really like to applaud your attention to this detail. Anaphylaxis does claim a number of lives, and this is a potentially life-saving intervention. These are -- and this has been the subject of a lot of news -- expensive items. Though I think the cost-to-benefit ratio certainly favors doing this.

I was struck by the last provision in this section regarding training by a State-approved or nationally-recognized provider. I assume you have some examples of this. I hope that this is not overly burdensome. I routinely teach people to use these injectors upon

discharge from the emergency department, so I'm not sure what these programs are or what they represent. But I just want to make sure that we are not creating unnecessarily burdensome training for what is really quite a simple procedure.

MS. SCHIFF: So the state public health law requires exactly what we have proposed here, which is that there has to be, for a non-patient specific auto-injector, in order to have and maintain one and use one, you need to have a training by a nationally-recognized organization or a New York State-approved provider.

We will provide guidance about those trainers. I imagine that it is possible, that should this go into effect, more trainers will appear. We have found at least one trainer that provides an online training that is 45 minutes and $25.

DR. RICHARDSON: 45 minutes?

MS. SCHIFF: So that is what's available so far. Perhaps market forces

will develop additional trainings that would be approved.

DR. BASSETT: Thank you.

MS. REDLENER: (Indicating.)

DR. BASSETT: Ms. Redlener.

MS. REDLENER: I think this is a very important proposal. I'm just wondering what the regulation is for schools in general. This is for daycare and early childcare, but do public schools have the same requirement?

DR. ASKEW: It's very similar. I just want to make sure I don't get it wrong, there's very similar requirements in schools already.

MS. REDLENER: Already. Thank you.

DR. CARO: (Indicating.)

DR. BASSETT: Dr. Caro. I believe, and I hope I haven't gotten this wrong, that about half of administered epinephrine in schools are to children who didn't have documented allergies.

DR. CARO: I'm just wondering, since the dose for adults and children are not the same, and for children the age is

very important, that can be, in the implementation phase, something that worries me.

DR. BASSETT: I think the question is, have we looked into having the correct injector?

MS. SCHIFF: So currently, the auto-injector comes essentially in young children and older children and adults. There is another pharmaceutical company that has FDA approval to market an auto-injector for babies and toddlers. That will be on the market by the end of the calendar year.

So our guidance -- and that may be why the training is a little bit longer, because there is an issue about dose. So our guidance will make it clear, and childcare programs, as you may know, are permitted based on the age of the children. So there are programs that are designed as infant and toddler programs, so they would be -- and the weight of the children there -- as a general matter, aligned with the new

auto-injector that will be available for very young children. And then we have programs for preschoolers, so that child-based auto-injector would be appropriate.

DR. BASSETT: Great. Were there other questions or comments? If not, let's move on to the training component. Dr. Raju, you had a question on the training requirement?

DR. RAJU: Yes. My comment is, is it a one-time training, or does it have a refresher course being offered?

MS. SCHIFF: Different trainings are for different periods of time. So many of the trainings are one time. There are some trainings that are every two years. So the CPR certification is something that you need to renew every two years. Again, where we did not state the timeframe in the proposal, then it's one time. Otherwise, we specified when it needs to be taken again, and in our guidance we would set that out in a way that would be clear

for the provider so they will know exactly how frequently the staff needs to be trained.

DR. RAJU: The training is purely -- does it also include a competency demonstration component, or is the training on it just purely you take the slides and you sit through the courses?

MS. SCHIFF: It depends on training, some of them. So to get CPR certification, there is a test you need to take, and others are a video that you watch and probably get a certificate at the end. But there may or may not be a test. So some have tests and some don't.

DR. FORMAN: (Indicating.)

DR. BASSETT: Dr. Forman.

DR. FORMAN: Thank you. I just had a quick clarification. Something at the end there said a requirement for pediatric CPR and first aid. I'm only aware of a standard CPR course that includes children and adults. I'm not aware of a separate pediatric CPR

course. Then I'm wondering what exactly you are referring to for pediatric first aid. Is that some sort of a separate training?

MS. SCHIFF: So if the class addresses both, it wouldn't need to be something that's specifically labeled pediatric CPR and first aid. But we wanted to make sure -- and that is also something that is highlighted in the new childcare development block requirements -- that the class includes a pediatric component.

DR. FORMAN: So a standard CPR training with the American Red Cross does include that. You are tested on mannequins that are infant, child, and adult. I've never seen one that doesn't.

DR. RICHARDSON: I've seen a lot of adult-only CPR classes. So it has to include the pediatric component.

DR. FORMAN: That reflects my biased experience. As a pediatrician, I never take a course that doesn't have a kid

teaching in it.

DR. BASSETT: Thank you. Are there any other questions or comments?

(No response.)

DR. BASSETT: On this, I believe, we again have to take two votes separately for Article 43 and Article 47. Let's take the vote first on the proposed resolution to amend Article 43.

Again, you are being asked to approve these for publication for public comment. May I have a motion?

MS. REDLENER: (Indicating.)

DR. RAJU: Second.

DR. BASSETT: Thank you and a second. All in favor, please say yes.

ALL: Yes.

DR. BASSETT: Any nos or abstentions?

(No response.)

DR. BASSETT: Thank you. The motion passes unanimously.

The next is the proposed resolution to amend Article 47. This had some additional components, if you recall, we

went over this morning. May I have a motion to approve this for publication?

DR. GOWDA: (Indicating.)

DR. RAJU: So move.

DR. BASSETT: And a second.

DR. RICHARDSON: (Indicating.)

DR. BASSETT: All in favor, please say yes.

ALL: Yes.

DR. BASSETT: Good. The motion passes unanimously. Thank you very much.

We had two presentations planned this morning, but I think we had a robust discussion, and we may not have time for both presentations. The first one was a presentation to update you on seasonal flu. And because that will be irrelevant come June, I suggest that we start with that presentation from Dr. Daskalakis. Flu season ends officially at the end of May but who knows, with climate change.

DR. DASKALAKIS: So thankfully, we will hopefully be irrelevant by June. I

will give you the update on, really, influenza activity, as well as -- I should probably say my name again, Demetre Daskalakis, the Deputy Commissioner for Disease Control, for the record.

I will give you an update on influenza activity for this year, as well as our activities around vaccination, as well as details of vaccine efficacy. Just to remind you, if you are in healthcare, you are aware of this already, that this was a very active non-pandemic influenza season, the most since 2003, 2004.

This season, the circulating virus was dominated by H3N2, which is known to generally cause more severe disease than other influenza viruses and also have some issues with development of vaccine as it passes through egg. We have seen increased numbers in out-patient visits, hospitalizations, deaths, and institutional outbreaks.

It is a typical season in that this

is most severe in the elderly, but also a bit atypical, because we saw that the most affected, other than the elderly, were middle-aged adults, actually more than young children. This is a graph that shows New York City laboratory surveillance on influenza. I will walk you through this quickly. It's the number and percentage of flu swabs that are positive for influenza, as well as, actually, RSV we're showing as well.

So you will see first the bars. You will see the bars, the majority of activity that we've seen so far this year has been Flu A, although we have seen Flu B. This blue line represents the percent of positive swabs for influenza in this season. You will see that compared to prior seasons, which is 2016, 2017, we have a lot of positivity. So this peaked February 10th with 35 percent of our specimens positive for flu, so that is a lot of flu.

Notably, RSV really mirrored last year, so not a lot of an increase in RSV

activity. So a lot of influenza A, some influenza B, and a lot more than last year, so a very active flu season from the perspective of lab surveillance.

Moving away from lab surveillance and looking at surveillance of influenza-like illness visits to emergency departments, in this condensed graph you will see a time from 2001 to 2018. This is in the 2003, 2004 Fujian season that, if you recall, was a terrible flu season. You will see that the peak of influenza-like illness visits to emergency departments was high but not quite as high as 2003. About 8.9 percent of visits at the peak of the season were due to influenza-like illness, which I see that you are nodding.

So there were a lot of flu visits and a lot of activity. Another way of looking at this, and I think this is an interesting way of looking, that also may be commented on, the fact we've seen less ED visits. You also see the

out-patient visits in non-ED settings are also up, and significantly up from prior years.

So that red line represents visits to out-patient venues, 2017 to '18, and when you compare that to last year, which is the blue line, you will see that there was a lot of activity with folks going to out-patient venues, which they also include urgent cares. So we have a lot of folks pursuing care.

We do have data showing U.S. hospitalizations. This is where we saw a little bit of a difference in trend. So though the colors are hard to see, the curve that you see here is among elderly patients. Usually, the next curve that you would see is youth. This year, we're actually seeing middle-aged showing increased activity, and so that is 50 to 64-year-olds, and that is in pink, which you can see is the second curve.

So following them are the 0 to 4-year-olds, so a little bit different.

I believe they have a couple of hypotheses for why that is. But definitely a lot of influenza hospitalization happened this year compared to prior non-pandemic years.

Also, from the perspective of pediatric deaths, the country had 97 deaths in the United States so far. In New York City, we have had four pediatric deaths. This is not above average; we tend to see zero to eight deaths since 2004. Again, this season seems to be more severe among elderly and middle-aged adults than otherwise among children.

Again, there may be some ideas, and we will talk a little bit more about vaccine efficacy when we get to that part of this presentation. We will also note that there were increased numbers of outbreaks reported to us in long-term care facilities. It's important to note that our methodology for measuring these changed in 2013. So though these are interesting bars for the picture, I

would really focus on 2013 on when you're looking at these outbreaks in long-term care facilities. So it's notable that in this flu season, we have many, many reports. So we are not out of this season yet, so we still may have more to come. But a lot of activity in long-term care facilities.

We continue to do a lot of work to promote influenza vaccination throughout the jurisdiction. So some of our routine work was our normal kick-off event with Dr. Bassett giving the Mayor his flu shot. So thanks, Dr. Bassett, for doing that very public important demonstration of the importance of influenza vaccination.

There's a city-wide influenza media campaign, and I will show you that in a moment. There are ads in subway stations, subway cars, and bus stations, as well as a lot of digital social media on Facebook and Twitter, as well as Instagram. We continue to distribute vaccines for children through the VFC

Program. We give pediatric care providers a report card of how they are doing from the perspective of coverage of flu vaccine practices.

We issue health alerts, provider letters. We continue to make it very easy to find flu vaccines. So pretty much, in New York City, everywhere you turn you'll trip over it. And if you don't know where to find it, you can go to our vaccine locator on our website or call 311, or text 877877 either flu or "gripe," to find out where you can get your shots. So we have a lot of ways to help people localize flu vaccines.

So this is an example of our City-wide flu media campaign, "We got our flu shots, not the flu." So these ads were throughout the City, both in English and in Spanish.

We also had some specific response based on the severity of this influenza season. The first is that we provided a lot of technical support to pharmacies to support Governor Cuomo's executive

order that allowed them to vaccinate children ages two to 17 in those pharmacies. We partnered with Walgreens to provide 1000 vouchers to uninsured or underinsured adults and children ages greater than or equal to seven years of age. So that age cutoff is important because that's when those pharmacies actually allow vaccinations. So under seven, they do not vaccinate. There are some pharmacies that do, but Walgreens and Duane Reade do not.

We participated in a flu phone bank with Telemundo and NBC. We distributed TENIMOR (phonetic), a vaccine for children, to meet the demand. We also sent a letter to providers that asks that their VFC providers waive the administration fee during this emergency time. So we are not able to measure that and say how many providers did it, but we did ask for them to take this step. And we partnered with our Office of School Health to promote flu vaccination in our school-based health

centers.

So in terms of what we've seen this season, flu vaccination rates did increase for children and adolescents. And actually, most of that increase was in response to the emergency order, so it was an effective public comment to pursue that in support of the Governor's order.

Flu vaccinations have already surpassed last year's. So it's 45.7 compared to 45.4 percent at the end of last flu season. And we expect this to increase a little more, but we've definitely seen a drop-off in vaccination that goes along with the thankful drop-off of influenza activity.

In terms of any flu vaccines given to children and adolescents, you will see that the majority of vaccines were given in the fall, which is our ideal, early in the season. But you will note that really the bars for this year, the sort of yellow and gold bars versus the -- I think they project as purple,

but they look blue on my screen -- the blue or purple bars, depending on where you are looking, represent last season. We definitely see an increased flu vaccination compared to last year. In fact, about 104,000 more doses were given this year compared to this time last year.

And something that we think is really important, and I think this graph is one of my favorites at representing, in terms of influenza vaccination activity, is what happens with the executive order. So when pharmacies were allowed to give vaccines to folks that were younger, we actually saw really significant increases in immunization both among patients 18-plus and less than 18 years of age. So the real message, I think, there is that pharmacies are a very great place for folks to access influenza vaccine. So the other wonderful thing about this is to show you that this is this year's executive order, that was on January 25,

2018, and when you compare that to the executive order in 2013, we really got a lot of traction out of the order that happened this year. So I think that the message was really clear. It combined our messaging as well as other messaging; I think it was really effective in getting folks vaccinated.

Still, though, when you look at pharmacy vaccination among children, about 85 percent of the vaccine was given to children seven years or older. So, again, that is both partially because of unwillingness of parents to bring children under seven to pharmacies for vaccination, and some of the limits set by pharmacies. So some places would vaccinate under seven, some don't. So that may be a little bit of a manifestation of that difference.

Finally, the last thing I want to talk about before I take questions is just to talk a little bit about vaccine effectiveness and what we've seen, sort of in the interim, vaccine effectiveness

analysis done by the CDC. So overall, the interim vaccine effectiveness is thought to be 36 percent. For the more commonly circulating strain, H3N2, it's 25 percent for all comers. For H1N1, about 67 percent, and for Flu B, 42 percent.

So not bad, better than expected, and compared to some of the media that early on in the season was misreporting our vaccine efficacy to be 15 percent, based on data from Canada and Australia, really demonstrates that vaccine efficacy is very geographic and that you can't extrapolate vaccine efficacy from other jurisdictions into your jurisdiction. The other example being that when Australia had 15 percent vaccine efficacy, New Zealand had a much higher vaccine efficacy and they are neighbors.

Then finally, potentially one of the reasons that we saw better results in children than in adults is that the vaccine looks like it worked better in

kids. So the efficacy approached 59 percent for children six months to eight years, while it was significantly lower in adults. So there are a lot of reasons why this could be.

The bottom line is that vaccine works, and remember, vaccine efficacy measures prevention of flu when people who get the vaccine are less likely to be hospitalized with pneumonia and other complications, and that is unmeasured in vaccine efficacy. Thank you.

DR. BASSETT: Thanks. Any questions or comments? I should point out that the State is bringing legislation to codify the pharmacy vaccinations for children over two, which we are in support of and have been in support of for some time.

So it's still not too late to get a flu shot. I should end with that comment. Thank you very much for a very thorough presentation.

DR. DASKALAKIS: Thank you.

DR. BASSETT: Well, we have ten

minutes remaining, and I really think we should just call it a day. I want to apologize to Dr. Maybank, who I want to thank for being present to give a presentation on something that is a very high priority for me, reviewing our strategy for neighborhood health and the promotion of health equity across our City. So we will table that one and have the presentation at a later date.

With that, I would like to adjourn the meeting. Thank you all.

(TIME NOTED: 11:50 a.m.)

C E R T I F I C A T E

STATE OF NEW YORK)
ss:
COUNTY OF NEW YORK)

I, Danielle Rivera, a shorthand reporter within and for the State of New York, do hereby certify that the within is a true and accurate transcript of the statement taken on March 13, 2018.

I further certify that I am not related to any of the parties to this action by blood or by marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 13th day of March 2018.

DANIELLE RIVERA